

THE DIVISION OF HEALTH, OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-020754
STATE FILE NUMBER

FILED JUN 30 1958

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 208

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Adair | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville | | c. CITY OR TOWN Kirksville ⁰⁰¹³ ₀ | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 111 E. Illinois | | Length of stay in 1b St. 9 mo. | |
| d. STREET ADDRESS 111 E. Illinois | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or print) First Walter Middle Oran Last Gowdy | | | 4. DATE OF DEATH Month June Day 19 Year 1958 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED | 8. DATE OF BIRTH Nov. 29 1894 | 9. AGE (In years last birthday) 63 | IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist | | 10b. KIND OF BUSINESS OR INDUSTRY Drug Store | | 11. BIRTHPLACE (City and state or country) Mills Shoals, Ill. | |
| 12. CITIZEN OF WHAT COUNTRY? U S | | 13. FATHER'S NAME Oscar Gowdy | | 14. MOTHER'S MAIDEN NAME Della Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W W # 1 | | 16. SOCIAL SECURITY NO. 497-09-2170 | | 17. INFORMANT Helen Gowdy, 111 E. Illinois, Kirksville, Mo. | |

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|--|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion (D.O.A. Kirksville Osteopathy Hosp.) (Coronary attack while mowing grass) | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4201 | | | |
| DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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|---|--|------------------------------|--------------|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour 6:30 a. m. p. m. Month, Day, Year | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |

| | | | |
|--|--|--|---|
| 21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at 6:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>Nova E. Foster</i> Nova E. Foster | | 22b. ADDRESS 402 N. Elson, Kirksville, Mo. | 6/19/58 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 6/22/58 | 23c. NAME OF CEMETERY OR PLACE OF BURIAL Oakwoods |
| 23d. LOCATION (City, town, or county) Macon, Macon, Mo. | | (State) | |

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|--|--|-----------------------------------|--|---|
| 24. GENERAL DIRECTOR <i>Nova E. Foster</i> Nova E. Foster | | ADDRESS Kirksville, Mo. | 25. DATE RECD. BY LOCAL REG. 6-21-58 | 26. REGISTRAR'S SIGNATURE <i>Drew W. Rathiff</i> Drew W. Rathiff |
|--|--|-----------------------------------|--|---|

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

JUN 30 1958
FEB 18 1959

MAR 3 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Nova E. Foster*
Nova E. Foster

Licensed Embalmer No. 4742
Kirksville, Mo.
P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.